LOS ANGELES COUNTY COMMISSION ON HIV

3530 Wilshire Boulevard, Suite 1140 • Los Angeles, CA 90010 • TEL (213) 738-2816 • FAX (213) 637-4748
www.hivcommission-la.info

PLANNING, PRIORITIES & ALLOCATIONS (PP&A) COMMITTEE MEETING MINUTES

June 24, 2014

PP&A MEMBERS PRESENT	PP&A MEMBERS ABSENT	PUBLIC	COMM STAFF/ CONSULTANTS
Brad Land, *Co-Chair*	Al Ballesteros, MBA, *Co-Chair*	David Kelly	Jane Nachazel
Michelle Enfield	Sharon Holloway/Ismael Morales	Don Lundy	Craig Vincent-Jones, MHA
Rev. Alejandro Escoto, MA	Miguel Martinez, MPH, MSW	William Paja	
Susan Forrest	Marc McMillin	Michael Pitkin	
Lynnea Garbutt	Mario Pérez, MPH	Scott Singer	**DHSP STAFF**
Abad Lopez	LaShonda Spencer, MD	Lambert Talley	None
	Monique Tula		

CONTENTS OF COMMITTEE PACKET

1) **Agenda**: Planning, Priorities & Allocations (PP&A) Committee Meeting Agenda, *6/24/2014*
2) **Table**: Los Angeles County Commission on HIV, Continuum of HIV Services, List of Service Definitions, *6/24/2014*
3) **Diagram**: Los Angeles County Continuum of HIV Services, *2014*

1. **CALL TO ORDER:** Mr. Land called the meeting to order at 1:25 pm.

2. **APPROVAL OF AGENDA:**
   MOTION #1: Approve the Agenda Order **(*Passed by Consensus*)**.

3. **APPROVAL OF MEETING MINUTES:**
   MOTION #2: Approve the Priorities and Planning (P&P) and Planning, Priorities and Allocations (PP&A) Committee meeting minutes, as presented **(*Postponed*)**.

4. **PUBLIC COMMENT *(Non-Agendized or Follow-Up)*:** There were no comments.

5. **COMMITTEE COMMENT *(Non-Agendized or Follow-Up)*:** There were no comments.

6. **CO-CHAIRS' REPORT:** There was no report.

7. **FY 2015 PRIORITY- AND ALLOCATION-SETTING (P-and-A)**:
   A. List of Service Categories:
   - Mr. Vincent-Jones noted the Patient Flow Map is central to the Continuum of HIV Services (CHS) to ensure the CHS is designed in a patient-centered fashion that moves patients to the healthiest stage for them in their given context. Post-unification, the CHS includes HIV- persons as well as PLWH who are unaware of their status, not in care, or in care.
   - The CHS should assist PLWH in moving through the Patient Flow Map stages to the right from unaware; to aware, but not in care (unmet need); to accessing care; and finally to adherence to the PLWH's care plan. Concurrently, the CHS should assist HIV- persons in moving through the Patient Flow Map stages to the left from high to low risk of exposure.
   - There are two lists of service definitions: care and prevention. Care service definitions are more specific because HRSA issues a list and the Commission has adapted it over the years. CDC recommendations are much less precise so work is

necessary to ensure both sets are in a similar format. The purpose of unification was not simply to merge two sets of documents into one, but to form a new Commission and processes that reflect integration.

- The Standards and Best Practices (SBP) Committee determined the best way to address services comprehensively was to allow the CHS to drive the process. The CHS was first developed in 2007 based on the treatment cascade.
- The treatment cascade does not, however, address prevention or the community Viral Load (VL). Risk reduction and behavioral modification were added to address prevention. The treatment cascade also considers HIV testing one of the stages, but the CHS considers it a service/intervention designed to achieve early diagnosis.
- Arrows between Patient Flow Map stages reflect patient movement and potential leverage points to offer services/interventions to assist patients. Green arrows reflect desired movement while red arrows reflect backsliding.
- The SBP Service Definition Work Group chose to use leverage points to group services rather than using "prevention and care" silos. All services/interventions are stages of prevention success as care/treatment is prevention in helping to stem the disease. Treatment services are those specific to HIV such as medications so are most prominent among PLWH who are adherent. Care services include treatment, but also services that help link and retain PLWH in care.
- Mr. Kelly felt unmet need should be included in the stages of care success because care incorporates services such as linkage to care. Unaware might also be included. Mr. Vincent-Jones agreed those were good points. The current groupings of stages of success are somewhat subjective. He added all CHS diagram points can be quantified and tested.
- The SBP Service Definition Work Group is working to define what services/interventions are offered at each leverage point. For example, is mental health prevention or care? Services are offered at several leverage points, but must be defined to reflect the difference, e.g., between mental health in linkage to care versus retention in care. Services/ interventions associated with green arrows help patients move toward greater health while those associated with red arrows help mitigate backward movement, e.g., legal services address naturalization issues that may put care at risk.
- It is important to understand that pulling apart all the prevention and care service definitions to restructure them in this way will take considerably more work than was originally anticipated, but will result in a better service system.
- The SBP Service Definition Work Group has developed an initial list of services/interventions for each of the leverage points and is working to determine services/interventions for the end PLWH stage, adherent to care, and the end HIV- stage, low risk. It projects completing the list by the next PP&A meeting. Definitions will take longer, but the list will allow PP&A to review financial expenditure reports and address priority-setting.
- Mr. Kelly asked about the in care and adherent to care stages which show a public care box in front shadowed by a private care box. Mr. Vincent-Jones replied the configuration was developed in 2007 to reflect that patients in the CHS may access private care for some services. The landscape is more complex post-ACA with federally funded public care, public care for the indigent, ACA supported care and private care. Definitions may need to be developed in future.
- Mr. Kelly interpreted it to signal that SBP intends to engage the private sector. Mr. Vincent-Jones replied it offers SBP a platform to eventually do that, but ACA supported health plans would be addressed before private care.
- Mr. Singer asked how providers will be impacted by changing service definitions. Mr. Vincent-Jones felt it would not significantly impact their services, but the new approach puts all services in a consistent format. A key goal is to help shape the community's mindset to see services in a continuum rather than in prevention and care silos.
- The change also restructures P-and-A to make it more goal oriented. Service definitions combined with patient composites will provide the basic elements to drive P-and-A by the number of units per service for the first time.
- Finally, it forces PP&A to look at the purpose of each service and how it achieves a continuum goal. For example, he has become a proponent of substance abuse as a linkage to care strategy since data shows approximately two-thirds of clients have substance abuse or addiction issues and cannot be engaged in care long term until issues are addressed. That may mean extending linkage to care to six months for such clients to ensure they are prepared to engage in care.
- Allocations will still use percentages, but funds and the number of services will increase to reflect HRSA and CDC needs.

➲ Mr. Vincent-Jones will forward Mr. Land's suggestion to name arrows "human experience" to SBP.

➲ Agreed to change red arrows to yellow.

➲ Ms. Forrest noted the Department of Mental Health, Mental Health Task Force plans to discuss HIV-specific issues. She will report on the work at the next Commission meeting.

B. **Patient Composites**:

- Mr. Vincent-Jones noted allocations fund a service mix and utilization frequency per service to meet needs of those the system serves. The 2011 P-and-A process also adopted nine contingency scenarios to address projected changes due to ACA implementation with average funding per population based on service mix and utilization. Patient composites are constructs used to explore each population's needs. The last Comprehensive HIV Plan had 14 composites.

- Patients composites must be mutually exclusive and together represent all patients in the system. Exclusivity is needed to avert counting a patient need more than once, e.g., African-American and Latino patient needs may overlap.
- Mr. Kelly suggested SBP develop composites since they develop Population Specific Guidelines. Mr. Vincent-Jones said SBP does develop Guidelines, but PP&A identifies the populations. SBP suggested basing composites on CHS stages as they are mutually exclusive and represent all patients, but there are many options, e.g., by age or race/ethnicity.
- Mr. Land was concerned to reflect high versus low acuity patients within a CHS stage, e.g., some adherent patients may only need to see a physician four times a year while he needs to see one more often. Mr. Vincent-Jones replied stages could be used to develop basic composites with sub-composites developed to the extent they are considered useful.
- Mr. Singer noted the stages address HIV status, but a PLWH could be adherent to a care plan while also having a major substance abuse issue. Mr. Land added there are several important lenses such as substance abuse. Mr. Vincent-Jones replied PP&A can identify any sub-composites it finds of value, but it is important to remember that the purpose of patient composites is to develop a methodology for allocation-setting without being swamped in detail.
- Ms. Enfield suggested composites by SPA. Mr. Vincent-Jones said it was possible, but geomapping is replacing SPA data.
- Mr. Kelly suggested a focus on the service/intervention leverage points rather than stages. Mr. Vincent-Jones noted stages are, by definition, a quantity of patients while leverage points are not. Patient composites pertain to people.
- Mr. Singer suggested basing composites on status stage buckets, but refining them to reflect patients who are engaged or dis-engaged. Mr. Vincent-Jones felt the concept valuable, but difficult to apply. How is "engaged" defined? An adherent and healthy patient might attend three of four needed visits while a patient who is not healthy might attend five of eight needed visits and possibly a support group. A model has to have quantifiable data to work properly.
- Mr. Kelly suggested overlaying three key Commission concerns of disparity, access to care and stigma, but Mr. Singer noted they were not quantifiable. Mr. Vincent-Jones added SBP is developing a social determinants framework to address those areas. Decisions pertinent to that may return to PP&A and impact allocations just as other data does.

➲ DHSP will email and then present on service utilization data.

➲ Recommendation to Executive Committee for approval: Adopt a methodology of Continuum of HIV Services Patient Flow Map status stage buckets for patient composites with further review later on to decide and detail substrata patient composites as needed or determined according to the process.

➲ Mr. Vincent-Jones will draft a recommendation narrative to answer questions and reflect its value to the process.

8. **NEXT STEPS**:

   A. Task/Assignment Recap:

   ➲ Mr. Vincent-Jones will email Mr. Talley a copy of PP&A's Work Plan.

   B. Agenda Development for Next Meeting:

   ➲ Mr. Vincent-Jones is developing a list of topics for all the Committees. He will email it when completed.

   ➲ Mr. Vincent-Jones reviewed upcoming meeting topics:

   - 7/15/2014: summary of 2011 Los Angeles Coordinated Needs Assessment (DHSP), address additional pieces for consumer Needs Assessment, report on Medical Outpatient Fee-For-Service (DHSP), report from Comprehensive HIV Planning Work Group, review feedback on methodology and operational aspects of FY 2015 P-and-A process;
   - 7/22/2014: FY 2015 Priority-Setting using the new service definitions;
   - 8/19/2014: presentation on Medical Specialty (DHSP), new financial expenditures report (DHSP).

9. **ANNOUNCEMENTS**: There were no announcements.

10. **ADJOURNMENT**: The meeting adjourned at 3:20 pm.